CIGNA HealthCare
of Arizona, Inc.
A Business of Caring.

Authorization for the Disclosure of Protected Health Information

I, the undersigned, understand and agree to the following:

1. I have voluntarily scheduled my Biometric Health Screening appointment. I understand that I am not required to sign this Authorization, complete the attached Personal Health History Questionnaire (Questionnaire), or schedule or undergo the Biometric Health Screening testing, as a condition to enrollment, eligibility for benefits, treatment, payment or coverage under the Maricopa County medical plan. However, I further understand that unless I sign this Authorization, fully complete the attached Questionnaire and fully complete each of the Biometric Health Screening tests/measures to the extent I am able, I will not qualify for any reduction in my contribution to medical plan coverage through Maricopa County.

2. I understand that Maricopa County has arranged for plan administrator Connecticut General Life Insurance Company (CGLIC), its affiliate CIGNA HealthCare of Arizona, Inc. (CIGNA HealthCare) and CIGNA HealthCare vendor, Health and Fitness Concepts, Inc. d/b/a Employee Health Management Systems (EHMS), to schedule and conduct the Biometric Health Screening testing and to receive the results and review my responses to the Personal Health History Questionnaire and use and disclose the information as described below.

3. I consent to each of the following testing and/or measurements in connection with my Biometric Health Screening appointment: blood pressure, body composition analysis that includes height, weight, Body Mass Index (BMI), waist measurement, percent body fat, and a blood sample for the purpose of measuring my Total Cholesterol, HDL Cholesterol, calculated risk ratio, and/or Glucose levels.

4. I understand that I am entitled to receive a copy of this Authorization, the Questionnaire and my Biometric Health Screening results at the end of the appointment.

I authorize CIGNA HealthCare and/or EHMS to use and disclose my Protected Health Information as authorized by law and specifically for the following purposes:

a. CIGNA HealthCare and/or EHMS may disclose my name and employee ID number to Maricopa County to assure that I receive the reduction in medical plan contributions to which I am entitled. CIGNA HealthCare and EHMS will not disclose information provided by me on the attached Personal Health History Questionnaire (Questionnaire) or my Biometric Health Screening test results on an individually identifiable basis to Maricopa County, but only in the form of de-identified, aggregate reporting.

b. EHMS may disclose my Biometric Health Screening results and information provided on my Questionnaire to CGLIC and CIGNA HealthCare for its use in connection with administration of the Maricopa County medical plan and for its own health care operations.

c. Based on my Questionnaire responses and Biometric Health Screening test results, CIGNA HealthCare and/or EHMS may disclose my name and contact information to Magellan Behavioral Health, Inc. (Magellan). Magellan is contracted with Maricopa County to provide behavioral health and health coaching services. I understand that Magellan may reach out to me to determine my interest in participating in health coaching services.

I authorize the release of information from the Questionnaire and Biometric Screening testing in accordance with the provisions above, including the following information: CONFIDENTIAL HIV-RELATED AND COMMUNICABLE DISEASE INFORMATION (ARS § 36-661); CONFIDENTIAL ALCOHOL OR DRUG ABUSE TREATMENT PROGRAM INFORMATION (42 CFR § 2.1 et seq.); CONFIDENTIAL PSYCHOTHERAPY NOTES (42 CFR § 164.501); BEHAVIORAL / MENTAL HEALTH INFORMATION; CONFIDENTIAL GENETIC TESTING INFORMATION (ARS § 12-2801).

I hereby release Maricopa County, CGLIC, CIGNA HealthCare, EHMS and Magellan, and their affiliates, directors, officers, employees, agents and contractors and any other organization(s) associated with this Questionnaire and Biometric Health Screening, together with their successors and assigns, from any liability arising from or in any way connected with my participation in the Questionnaire and Biometric Health Screening or from the data derived therefrom.

I understand that: I may revoke this Authorization at any time by providing written notice to all entities listed in this Authorization; any information released in reliance on this Authorization and prior to such revocation shall not constitute a breach of my right to confidentiality; and that further redisclosure of this information is subject to the HIPAA Privacy Rule. This Authorization will expire upon the later of the completion of follow-up on issues raised by the Questionnaire and Biometric Health Screening results or one year from the date of its execution.

I understand that:

The data derived from these test(s) are considered to be preliminary; they are screening assessments only. They do not constitute any diagnosis and are for health information purposes only.

The responsibility for initiating a follow-up examination to confirm the results of this screening and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with this screening and/or health fair/event.

The chemical analyzer used to determine plasma glucose and serum lipid levels may yield results that are at variance from those produced by standard reference laboratory analyzers.

Signature: _____ Date: _____

Last Name: _____ First Name: _____ Middle Initial _____Employee ID#:_____

Screening Location: _____ Employer Group: _____